

Emergency Information Form for Children With Special Needs

Patient ID	Today's Date:	Who is completing this form? You must confirm consent to use this form		
	Your Name:	Is this the new form or just an update?	<input type="checkbox"/> Update	<input type="checkbox"/> New
	CONSENT REQUIRED			
	I (above named person) confirm that parent/ guardian consents to the use of this form <input type="checkbox"/> Consent			
	Patient's Name	Nickname		
	Birthdate	Address		
	Primary language	Parent/guardian name		
	Contact phone Home	Emergency contact name		
	Contact phone Work	Emergency contact number		
	Contact phone Cell			

Facilities & Providers	Care Provider	Provider's name	Specialties	All contact phone numbers (E-mail option)	Fax	
	Primary care					
	Specialist-1					
	Specialist-2					
	Specialist-3					
	Specialist-4					
	Specialist-5					
	Others					
	Primary Pharmacy (branch, phone)					
	Anticipated primary emergency department					
Anticipated tertiary care center						

Clinical Baseline	Diagnoses/problem list (list all) starting with most important
	Baseline physical findings
	Baseline vital signs
	Baseline neurologic status
	Immunologic competency status
	Synopsis of clinical status
	Medications (doses, purpose)
	Antibiotic prophylaxis (drug, dose, indication)
	Significant baseline lab/imaging/diagnostic studies
	Prostheses, appliances, advanced technology devices, life support
	Allergies: Medications, foods, substances to be avoided and why
Advanced directives (include date of last review)	
Procedures to be avoided and why	

ED Management	Describe common presenting problems/findings		Suggested studies	Treatment recommendations
	Problem-1			
	Problem-2			
	Problem-3			
	Problem-4			
	Problem-5			
	Problems-other			
Comments on child, family, or other specific medical issues				

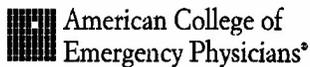
Immunizations	DPT dates	Varicella status
	Dtap dates	Hep B dates
	OPV or IPV dates	Hep A dates
	MMR dates	Meningococcal (Specify which one if possible)
	HiB dates	TB status
	Pneumococcal-7	HP virus
	Other	Other

Disaster Planning & Drills	Check or enter at least two of the most likely disasters that could affect this patient	
	<input type="checkbox"/> Power failure	<input type="checkbox"/> Fire, forest fire
	<input type="checkbox"/> Hurricane	<input type="checkbox"/> Infrastructure (roads, communication) damage
	<input type="checkbox"/> Tornado	<input type="checkbox"/> Shelter structure damage
	<input type="checkbox"/> Earthquake	<input type="checkbox"/> Food and water supply compromise
	<input type="checkbox"/> Flood	<input type="checkbox"/> Medication, supplies, equipment compromises
	<input type="checkbox"/> Tsunami	<input type="checkbox"/> Nuclear radiation accident (fallout, meltdown, contamination, detonation, etc.)
	<input type="checkbox"/> Blizzard	<input type="checkbox"/> Explosion/blast
	<input type="checkbox"/> Avalanche	<input type="checkbox"/> Other (e.g., terrorism, biological accident, chemical accident, other weather event)
	<input type="checkbox"/> Land/mud slide	
Other (describe)		Other (describe)

Disaster drills reviewed or practiced with patient. Documentation of completed drills and planned dates for future drills.

Date	Disaster type	Example drills: verbal review Paper review Table top model Computer simulation Hand on practice Equipment review In home review Alternate electrical power Electric generator use	Describe type of drill

Medical caregiver or physician's Name: (Print)	Medical caregiver or physician's signature:	Date:
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DELAWARE HEALTH AND SOCIAL SERVICES
 Division of Public Health
 Office of Emergency Medical Services